Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY SPECIALTY HOSPITAL OF AMERICA
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

May 28, 2013

MFDR Tracking Number

M4-13-2461

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did not make payment according to the Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula. The sum of the Medicare facility specific reimbursement amount shall be multiplied by 108% plus implants at cost plus 10%... Provider submitted a bill to the Carrier on October 17, 2012 and did request Separate Reimbursement of Implantables. On March 14, 2013 the Provider sent a fax to the Carrier requesting an Explanation of Benefits as evidence of final action … The Carrier is required to reimburse Provider **$44,114.68** pursuant to the Inpatient Fee Guideline. The Carrier made a partial payment of **$20,829.04.** Therefore, the Carrier is required to reimburse Provider an additional amount of **$23,285.64,** plus any and all applicable interest."

Amount in Dispute: $23,285.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent had reimbursed Requestor pursuant to the DWC Rules. Payment was made in accordance with the Medicare inpatient hospitalization specifications with separate reimbursement for the implantables…. In regards to the implantables, the UB-04 shows the billed amount for implants was $56,392.00. Requestor's letter indicates that the total cost of the implants was $17,758.36. However, the invoices provided with the DWC-60 only show invoicing totaling $7,281.83 ($1,311.00 + $5,970.83). Respondent is unable to determine how the $17,758.36 was derived based on the documentation provider."

Response Submitted by: Downs Stanford, P.C.

Respondent's Supplemental Position Summary submitted 07/16/2013: "Respondent received additional documentation on 7/1/13. On this date Requestor provided an invoice in the amount of $11,416.86. This invoice had never been presented to the Respondent for payment. It appears, thus, Requestor has tried to circumvent the DWC rules regarding medical bill submission…..Based on this documentation, the required conclusion is that Requestor has not properly submitted the invoice in the amount of $11,416.86 to Respondent."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2012 to September 18, 2012	Inpatient Hospital Surgical Services	$23,285.64	$15,898.92

FINDINGS AND DECISION

This amended finding and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 07, 2012
   - W1 – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated April 23, 2013
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. Did the requestor submit invoices in accordance with Texas Administrative Code §134.404?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 143 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for

that reason, the requirements of subsection (g) apply.

3. Per the Respondent's supplemental position summary "Respondent received additional documentation on 7/1/13. On this date Requestor provided an invoice in the amount of $11,416.86. This invoice had never been presented to the Respondent for payment. It appears, thus, Requestor has tried to circumvent the DWC rules regarding medical bill submission by submitting this invoice for payment directly to Medical Fee Dispute Resolution instead of submitting with their actual medical bills sent directly to the Respondent…..Respondent asks that this invoice in the amount of $11,416.86 not be included in the review of the Medical Fee Dispute Resolution case."

   According to Texas Administrative Code §134.404(g)(2) "A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute)…" The Respondent's argument that the Requestor improperly submitted the invoice is not supported. The invoice in the amount of $11,416.86 will be reviewed for reimbursement in accordance with §134.404(g)

4. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	Liquid Gen 1.25 ML	LiquidGen 1.25ml Allograft	$5698.73	$5,698.73	$569.87
278	Reset Patch 4 x 4 CM	Reset Patch 4 x 4	$5523.13	$5523.13	$552.31
278	Femoral Compnent SZ2	L uncoated RLM REM	$3300	$3300	$330.00
278	Tibial Baseplate SZ2	Size 3 LNP CoCr Tib Baseplate	$1200	$1200	$120.00
278	Patellar #2 7.5MM	7.5mm, UHMPWE Round	$570	$570	$57.00
278	Poly 3/4 10MM Cong	Size 3.4 10mm	$930	$930	$93.00
278	Wax, Bone	Bone Wax	$49.00	$12.38	$1.24
278	Bone Cement	No invoice provided	$0.00	$0.00	$0.00
				$17,234.24	$1,723.42
				Total Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 470, and that the services were provided at SURGERY SPECIALTY HOSPITAL S.E.. Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $54,416.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $23,614.91. This amount multiplied by 108% results in an allowable of $25,504.10.
   - The total net invoice amount (exclusive of rebates and discounts) is $17,234.24. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,723.42. The total recommended reimbursement amount for the implantable items is $18,957.66.

   Therefore, the total allowable reimbursement for the services in dispute is $25,504.10 plus $18,957.66, which equals $44,461.77. The respondent issued payment in the amount of $28,562.85. Based upon the documentation submitted, additional reimbursement in the amount of $15,898.92 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result the amount ordered is $15,898.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15,898.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	10/ /13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.